Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

HEALTH AND RECOVERY SERVICES ADMINISTRATION (HRSA)

OUT OF STATE MEDICAL SERVICES REQUEST

All questions must be completely answered for HRSA to review your request.

DATE

CLIENT NAME		PIC NUMBER (AB-122300-SMITH-A)
REQUESTING PHYSICIAN NAME		TELEPHONE NUMBER
CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER

Please list all sources of medical insurance:

NAME OF PHYSICIAN WHO WILL PROVIDE THIS SERVICE	TELEPHONE NUMBER	FAX NUMBER

Name of hospital or facility: _____

Is the hospital/facility a Washington Medicaid Provider? ☐ Yes ☐ No

If yes, what is their provider number? (7 digits) _____

Please Note: The hospital and providers must be willing to accept Washington Medicaid's out of state care reimbursement rate.

CLIENT'S ICD-9-CM DIAGNOSIS CODE(S) AND DESCRIPTION

Treatment /procedure/surgery description you are requesting including the applicable CPT procedure codes?

ESTIMATED LENGTH OF STAY	☐ Inpatient or ☐ Outpatient Services?
ESTIMATED DATE OF DEPARTURE	ESTIMATED DATE OF RETURN

Is there peer reviewed literature in support of this particular treatment? ☐ Yes ☐ No Please attach copy.

An evaluation and recommendation for the client's treatment from one of the following Centers of Excellence is required: University of Washington Medical Center, Sacred Heart Medical Center in Spokane, Oregon Health Sciences University in Portland; or if request is for a child, Mary Bridge Children's Hospital and Health Center in Tacoma or Children's Hospital and Regional Medical Center in Seattle. Please provide a copy of the evaluation with the recommendation for the client's treatment and where the service should be provided.

Is this treatment/procedure/surgery available in the State of Washington? ☐ Yes ☐ No

Please indicate why this client requires out of state care:

What alternative diagnostic/treatment options were explored for this client in the State of Washington?

What other hospitals/facilities can perform this procedure? For each hospital, please supply the following information:		
HOSPITAL/FACILITY NAME		
CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER

Will the client need transportation? ☐ Yes ☐ No

If air ambulance is requested, what are the special instructions for transport?

Does the client require a respiratory therapist? ☐ Yes ☐ No

Is the client on a vent? ☐ Yes ☐ No

Will the client need to be escorted by a caregiver? ☐ Yes ☐ No

If yes, please state the name and relationship to the client:

We require the following information along with your request:

- Complete medical history with labs
- Evaluations and treatments already explored

Send to:
Medical Request coordinator
Telephone: (360) 725-1584 – Fax (360) 586-1471